MEDICAL HISTORY

NAME _____ **DATE** _____

CURRENT MEDICATIONS

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

DRUG ALLERGIES

1. _____

2. _____

3. _____

4. Others _____

REVIEW OF SYSTEMS (Check those you have experienced in the past 6 months)

- ☐ Headache
- ☐ Dizziness
- ☐ Loss of vision
- ☐ Double vision
- ☐ Slurred speech
- ☐ Trouble swallowing
- ☐ Weakness
- ☐ Clumsiness
- ☐ Numbness or Tingling
  - ☐ Arms / Hands
  - ☐ Legs / Feet
- ☐ Loss of balance of falling
- ☐ Trouble walking
- ☐ Loss of memory
- ☐ Nervousness/anxiety
- ☐ Depression
- ☐ Fatigue/Loss of pep
- ☐ Trouble falling asleep
- ☐ Trouble staying awake
- ☐ Fever/Chills
- ☐ Unexplained Weight Loss
- ☐ Sweats
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Sinus drainage
- ☐ Neck pain
- ☐ Back pain
- ☐ Stiff or Swollen Joints
- ☐ Muscle pain
- ☐ Rashes
- ☐ Cough
- ☐ Shortness of breath with activity or at night
- ☐ Snoring
- ☐ Chest pain or tightness
- ☐ Palpitations
- ☐ Swollen ankles.
- ☐ Leg cramps.
- ☐ Restless legs
- ☐ Stomach or Belly Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Bloody or black stools
- ☐ Loss of bowel or bladder control
- ☐ Difficulty urinating
- ☐ Urgent or frequent urination
- ☐ Painful urination
- ☐ Sexual difficulties
- ☐ Abnormal vaginal bleeding
- ☐ Irregular periods
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Easy bruising
- ☐ Excessive bleeding

PAST HISTORY (Check all those that apply to you.)

☐ High Blood Pressure	☐ Seizures	☐ Blood Clots
☐ Diabetes	☐ Tuberculosis	☐ Depression
☐ Cancer	☐ Asthma or Emphysema	☐ Anxiety disorder
☐ Rheumatoid Arthritis	☐ Heart attack or angina	☐ Other Mental illness
☐ Gout	☐ Irregular heartbeat	☐ Addiction to alcohol
☐ Thyroid disease	☐ Abnormal heart valve	☐ Addiction to other drugs
☐ Osteoporosis	☐ Aortic aneurysm	☐ HIV - AIDS
☐ Glaucoma	☐ Poor circulation	☐ Major Trauma (accidents, falls)
☐ Migraine headaches	☐ Ulcers in stomach or intestines	☐ Broken Bones
☐ Loss of consciousness	☐ Kidney problems	☐ Prednisone Use
☐ Stroke or TIA	☐ Liver problems	☐ COVID-19
☐ Severe head injury	☐ Bowel problems	☐ Croup in childhood
☐ Brain Aneurysm	☐ Easy Bleeding	☐ Other _____

SURGICAL HISTORY (Please check any operations that you have had.)

☐ Tonsillectomy	☐ Appendectomy	☐ Gallbladder	☐ Carotid endarterectomy
☐ Hysterectomy	☐ Neck operation	☐ Heart surgery	☐ Tubal ligation
☐ Bypass in the legs	☐ Back operation	☐ Brain surgery	☐ Abdominal aneurysm
☐ Bowel surgery	☐ Gastric Bypass	☐ Other _____	

HOSPITALIZATIONS

_____

_____

_____

OTHER ISSUES

_____

SIGNATURE _____ **DATE** _____